Clear Form Data
FILLABLE FORM

Minnesota Department of Human Services

Pre-kindergarten Allowance Program Application

What is this application for?

Use this application to apply for the pre-kindergarten (pre-k) allowance program. This program provides up to $4,000 per year to help families pay for child care/early education that will help their children get ready for school.

You may not use this application to apply for the Minnesota Child Care Assistance Program.

To qualify, your family must:

1) Live in one of these areas:
   - City of St. Paul
   - North Minneapolis
   - Wayzata School District
   - Blue Earth county
   - Nicollet county
2) Have a family income at or below 185 percent of the federal poverty guidelines. This is about $38,000 for a family of four.
3) Have one or more children who were 3 or 4 years old on September 1, 2007 or who will be 3 or 4 years old on or before September 1, 2008.
4) Be willing to enroll your eligible child or children in a child care/early education program for at least 12 hours per week.

To qualify, your child(ren) must:

1) Have been 3 or 4 years old on September 1, 2007 or will be 3 or 4 years old on or before September 1, 2008.
2) Be U.S. citizens or legal immigrants.

Who can complete this application?

Only parents or legal guardians can apply for this program.

What programs may families choose?

Families may pick an approved, high quality Head Start, child care or pre-kindergarten program with 3 stars, 4 stars or provisional rating through Parent Aware or a provisional approval through the Minnesota Department of Education. Parent Aware is a rating tool for selecting high quality child care and early education. (Go to www.parentawareratings.org for more information about the Parent Aware program.) If there are no programs with 3 or 4 stars or are provisionally approved in your area, you can use the allowance at another program, but the program must be working toward achieving 3 or 4 stars and the allowance may only be used for quality improvement.

Families may pick a program open on the days that work best for them, as long as children are enrolled for at least 12 hours per week.

What if I already receive funding for child care through the Child Care Assistance program?

You still are eligible for the pre-k allowance program. If you pick an approved program, you can use the allowance to pay for any parent charges or fees that are not covered through Child Care Assistance. If you can not find an approved program, you can use a program that is not approved, but it must be used for quality improvement.

What do I need to do with this form?

1) Answer all questions on the form using black ink. If you need more space, write the number of the question and the answer on the back of the signature page or on a separate piece of paper. Include it with the application.
2) Attach proofs. Required proofs are listed after each question.
3) Sign and date the application.
4) Carefully read the Notice of Privacy Practices and the Your Rights and Responsibilities form. Keep copies of this information.
5) Mail or bring the completed form and all other needed items to the address listed below. **Do not fax this form.**

What happens next?

Staff at your allowance office will process your application. They will send you a letter letting you know if your child or children qualify for an allowance.

Mail application to:

Resources for Child Caring
Attn: Katie Holmes
10 Yorkton Court
Saint Paul, MN 55117-1065

If you want help, please call the telephone number listed in the contact information above.

Questions?

Contact the allowance worker at the address and phone number listed above.

What if I need free help translating this application?

Attention. If you want free help translating this information, call Language Access Line at 651-665-0150 or 1-888-291-9811.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم 651-665-0150 أو 1-888-291-9811.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Language Access Line 651-665-0150 ឬ 1-888-291-9811 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Language Access Line 651-665-0150 ili 1-888-291-9811.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Language Access Line 651-665-0150 lossis 1-888-291-9811.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ Language Access Line 651-665-0150 ຫຼື 1-888-291-9811.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, lakkoofsi bilbiltu Language Access Line 651-665-0150 ykn 1-888-291-9811.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните Language Access Line 651-665-0150 или 1-888-291-9811.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, wac Language Access Line 651-665-0150 ama 1-888-291-9811.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Language Access Line al 651-665-0150 o al 1-888-291-9811.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi Language Access Line 651-665-0150 hoặc 1-888-291-9811.

LH4-0011 (1-08)

What if I need this application in another format?

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.

1. Parent/guardian (applicant)

Tell us about you and where you live. Include **proof of your residence**, such as a copy of a recent utility bill, rental lease, or mortgage document.

FIRST NAME	MIDDLE NAME	LAST NAME	BIRTH DATE
OTHER NAMES YOU MIGHT BE KNOWN AS		RELATIONSHIP TO CHILD(REN)	
NAMES OF OTHER PARENTS OR LEGAL GUARDIANS IN THE HOUSEHOLD			BIRTH DATE
ADDRESS			
CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS *(if different)*			
CITY		STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	OTHER PHONE NUMBER	
PREFERRED SPOKEN LANGUAGE *(optional)*	PREFERRED WRITTEN LANGUAGE *(optional)*	DO YOU NEED AN INTERPRETER? ☐Yes ☐No	

2. Family members in the household

Tell us how many family members live with you. Include all adults, children and yourself. ☐

3. Children

Tell us about your preschool-aged children.

- List **all** children in your family who were 3 or 4 years old on September 1, 2007 or who will be 3 or 4 years old on or before September 1, 2008.
- Include **proof of the child's age**, such as birth certificate, crib card, passport, I-94 card, medical assistance card, immunization record, or baptismal certificate.
- If you answer "Yes" that your child is a U.S. citizen, you do not need to show proof of citizenship. If you answer "No", that the child is not a U.S. citizen and your family is not receiving Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP) benefits, you must include **proof that the child is a legal immigrant**, such as a Medical Assistance card or INS card. If your family is receiving the MFIP or DWP benefits, you do not need to provide proof of immigration status.

Child #1	FIRST NAME	MIDDLE NAME	LAST NAME	BIRTH DATE	GENDER ☐M ☐F
	IS CHILD A U.S. CITIZEN? ☐Yes ☐No	ETHNICITY *(optional)* Hispanic? ☐Yes ☐No	RACE *(optional– check all that apply)* ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Pacific islander/Native Hawaiian ☐White		
Child #2	FIRST NAME	MIDDLE NAME	LAST NAME	BIRTH DATE	GENDER ☐M ☐F
	IS CHILD A U.S. CITIZEN? ☐Yes ☐No	ETHNICITY *(optional)* Hispanic? ☐Yes ☐No	RACE *(optional– check all that apply)* ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Pacific islander/Native Hawaiian ☐White		
Child #3	FIRST NAME	MIDDLE NAME	LAST NAME	BIRTH DATE	GENDER ☐M ☐F
	IS CHILD A U.S. CITIZEN? ☐Yes ☐No	ETHNICITY *(optional)* Hispanic? ☐Yes ☐No	RACE *(optional– check all that apply)* ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Pacific islander/Native Hawaiian ☐White		
Child #4	FIRST NAME	MIDDLE NAME	LAST NAME	BIRTH DATE	GENDER ☐M ☐F
	IS CHILD A U.S. CITIZEN? ☐Yes ☐No	ETHNICITY *(optional)* Hispanic? ☐Yes ☐No	RACE *(optional– check all that apply)* ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Pacific islander/Native Hawaiian ☐White		

4. Benefits your family is receiving

Tell us if your family receives any of the following benefits:

- Diversionary Work Program (DWP) benefits? ☐Yes ☐No
- Minnesota Family Investment Program (MFIP) benefits? ☐Yes ☐No
- Child Care Assistance Program (CCAP) benefits? ☐Yes ☐No

If you answered "Yes" to receiving any of the benefits in section 4, skip to page 5.

5. Income

Does your family have any earned income?

☐Yes ☐No If yes, list all sources of earned income received by you and any other of your children's parents or guardians who live in your household. Include **proof of all earned income** (wages and profits), such as a pay stub, income tax records (tax forms or W-2 forms), or a signed letter from your employer.

Parent or Guardian#1	NAME	PAY RATE	#HOURS PER PAY PERIOD
	EMPLOYER NAME	HOW OFTEN PAID? ☐Daily ☐Weekly ☐Biweekly ☐Semimonthly ☐Other _____	
Parent or Guardian#2	NAME	PAY RATE	#HOURS PER PAY PERIOD
	EMPLOYER NAME	HOW OFTEN PAID? ☐Daily ☐Weekly ☐Biweekly ☐Semimonthly ☐Other _____	
Parent or Guardian#3	NAME	PAY RATE	#HOURS PER PAY PERIOD
	EMPLOYER NAME	HOW OFTEN PAID? ☐Daily ☐Weekly ☐Biweekly ☐Semimonthly ☐Other _____	
Parent or Guardian#4	NAME	PAY RATE	#HOURS PER PAY PERIOD
	EMPLOYER NAME	HOW OFTEN PAID? ☐Daily ☐Weekly ☐Biweekly ☐Semimonthly ☐Other _____	
Parent or Guardian#5	NAME	PAY RATE	#HOURS PER PAY PERIOD
	EMPLOYER NAME	HOW OFTEN PAID? ☐Daily ☐Weekly ☐Biweekly ☐Semimonthly ☐Other _____	

6. Child support

Does your family receive child support? Include **proof of child support**, such as child support payments/letter.

☐Yes ☐No If yes, how much?_____ How often? _____

7. I learned about the Pre-K Allowance Program through *(optional)*:

Important! Please read, sign and return this application.

If I am awarded an allowance, I understand:

- I must enroll the child receiving an allowance in an approved child care or early education program that has received 3 or 4 stars or a provisional rating from the Parent Aware program or provisional approval through the Minnesota Department of Education. If no approved programs are available, I must enroll the child receiving the allowance in a program working toward one of these criteria and the allowance may only be used for quality improvement.
- I must enroll the child receiving the allowance in the child care or early education program described above for at least 12 hours per week.
- I must give two weeks' notice to my allowance office worker and the child care or early education program providing services to the child receiving the allowance if I decide to transfer the child to another program or move to a new address.
- The Minnesota Early Learning Foundation or its agent will contact me about participating in the evaluation of the pre-k allowance program.

Authorization for release (sharing) of my information.

I give my consent for pre-k allowance staff to share information about my application for the pre-k allowance, my eligibility for the allowance, and the amount of any allowance that I receive with the child care or early education program that I choose to use for the pre-k allowance. I understand that this information must be shared to determine whether I am eligible for the pre-k allowance and to allow the pre-k allowance to be paid to the program on my behalf.

I also give my consent for pre-k allowance staff to share my information with the Minnesota Early Learning Foundation (MELF) and the entity chosen by MELF to evaluate the pre-k allowance program. I understand that my information must be shared so that MELF can evaluate the pre-k allowance program. I also understand that MELF or its evaluator will use my information to contact me and ask me to participate in the evaluation of the pre-k allowance program.

Generally, I must give my written consent for the pre-k allowance staff to give out the information listed above. If I do not consent, the information will not be released unless the law otherwise allows it. I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released. This authorization is good while I am applying for and enrolled in the pre-k allowance program, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel this authorization. If I refuse to sign or if I cancel the release, I may not be able to receive an allowance from the pre-k allowance program. An agency or person who receives my information through this release could possibly redisclose the information.

Fraud investigation release

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my allowance stops.

Declaration and signature

I declare that I have looked over my answers and believe they are all true and correct to the best of my knowledge.

By signing below:

- I acknowledge that I received a copy of the Notice of Privacy Practices (DHS-3979) and the Your Rights and Responsibilities pages from this form.
- I agree to the sharing of my information as described above.

SIGNATURE OF APPLICANT	DATE

Use this page if you need more space.

Tear off here

Your Rights and Responsibilities

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. You have been given a Notice of Privacy Practices (DHS-3979) information sheet. This sheet explains:
  - Why we are asking you to give us your private information.
  - How we may use and share private information about you.
  - Your rights about your private information. You can:
  - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask whom we have given your information to
    - File a privacy complaint.
  - How we must legally protect your private information.
  - Whom you can contact if you think your private information has been mishandled.

Please read it carefully. For more information about your data privacy rights, refer to the Notice of Privacy Practices section at the back of this form or ask your allowance office worker. You can also get a copy of this notice at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG.

- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. You may appeal within 30 days from the date you receive the notice by writing to the allowance program or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your allowance within 30 days, the agency can accept your appeal for up to 90 days from the date you receive the notice.)

  If you wish your allowance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your allowance worker to explain how the timing of your appeal could affect your present or future allowance.
- **Access to free legal services.** You may contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

  Minnesota Department of Human Services
  Office for Equal Opportunity
  PO Box 64997
  St. Paul, MN 55164-0997
  (651) 431-3040 (Voice)
  (866) 786-3945 (TTY)

  Minnesota Department of Human Rights
  190 East 5th Street, Suite 700
  St. Paul, MN 55101
  (800) 657-3704 (Voice)
  (651) 296-1283 (TTY)

Your responsibilities

- **You must enroll the child receiving an allowance in an approved child care or early education program that has received 3 or 4 stars or a provisional rating** from the Parent Aware program or provisional approval through the Minnesota Department of Education. If there are no programs in your area that meet these criteria, you must enroll the child receiving the allowance in a program working toward one of these criteria and the allowance may only be used for quality improvement.
- **You must enroll the child receiving the allowance in the child care or early education program described above for at least 12 hours per week.**
- **You must give two weeks' notice** to your allowance office worker and the child care or early education program providing services to the child receiving the allowance if you decide to transfer the child to another program or you move to a new address.
- **You must sign the application** to acknowledge that you have read and understand your rights and responsibilities under the allowance program.

Please keep the Rights and Responsibilities as well as the Notice of Privacy Practice pages for your records.

Minnesota Department of Human Services
Notice of Privacy Practices

(Effective Date: April 14, 2003.)

This notice describes how medical and other private information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services
- To decide if you can pay for some of your services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your household members need protective services
- To collect money from the state or federal government for help we give you.

Why do we ask you for your Social Security number?

We need your Social Security number to give you some kinds of financial help or child support enforcement services (45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]). We also need your Social Security number to check information you give us through matching programs that are part of an Income Eligibility Verification System (IEVS) (5 U.S.C. § 552a(o)(1)(D)).

You do not have to give us the number:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical Assistance only
- If you are from another country, in the U.S. on a temporary basis and do not have permission from the U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently
- If you are living in the U.S. without the knowledge or approval of the USCIS.

Do you have to answer the questions we ask?

You do not have to give us your personal information. We need this information to tell if you can get help from us. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

Sometimes we share information about you with other agencies. We will only share information as needed and as allowed or required by law. For example, we may share your information with the following types of agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative and nonprofit agencies
- Court officials, county attorney, attorney general, other law enforcement officials, and child protection and fraud investigators
- Child support officials
- Educational institutions and organizations
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Human services offices, including child support enforcement offices
- Anyone else the law says we must or can give the information.

What are your rights regarding the information we have about you?

- You may see and copy medical or other private information we may have about you. You may have to pay for the copies.
- You may give other people permission to see and have copies of information about you.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete.

Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.

- You have the right to ask us to share your information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must ask us to do this in writing. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations that we have shared your information with. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

What are our responsibilities?

- We must let you know our legal duties and privacy practices, which we are doing by providing you with this notice.
- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form unless we get special written permission from you. We may not share your information with individuals and agencies other than those listed on this form unless we get special written permission from you.
- We are required to follow the terms of this notice, but we may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices. When we change our privacy rules we will put them on our Web site at: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others to see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan or a pharmacy, you may send a written complaint either to the county agency, the organization or to the federal civil rights office at:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice) or
(800) 368-1019 or (866) 282-0659 (Toll free)
(312) 353-5693 (TTY)
(312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

Minnesota Department of Human Services
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998